

## Ear Nose & Throat Specialists, Inc.

### Pediatric Sleep Questionnaire

**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please answer the following questions by checking the box under the yes, no, or don't know column to the right.

<b>While sleeping, does your child...</b>	yes	no	Don't know
...snore more than half the time?			
...always snore?			
...snore loudly?			
...have "heavy" or loud breathing?			
...have trouble breathing, or struggle to breathe?			
<b>Have you ever...</b>			
...seen your child stop breathing during the night?			
<b>Does your child...</b>			
...tend to breathe through the mouth during the day?			
...have a dry mouth on waking up in the morning?			
...occasionally wet the bed?			
<b>Does your child...</b>			
...wake up felling <i>unrefreshed</i> in the morning?			
...have a problem with sleepiness during the day?			
Has a teacher or other supervisor commented that your child appears sleepy during the day?			
Is it hard to wake your child up in the morning?			
Does your child wake up with headaches in the morning?			
Did your child stop growing at a normal rate at any time since birth?			
Is your child overweight?			
<b>This child often...</b>			
...does not seem to listen when spoken to directly			
...has difficulty organizing task and activities			
...is easily distracted by extraneous stimuli			
<b>This child often...</b>			
...fidgets with hands or feet or squirms in seat			
...is 'on the go' or often acts as if 'driven by a motor'			
...interrupts or intrudes on others (e.g. butts into conversations or games)			